STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	C 05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure an intervention was in place to prevent falls for one resident (#1) of five residents reviewed. The findings included: Resident #1 was admitted to the facility on September 2, 2011, with diagnoses including Dementia, Sepsis, Paralysis, Muscle Weakness, and Anxiety. Medical record review of a Minimum Data Set (MDS) dated November 27, 2011, revealed "...a BIMS (brief interview for detecting mental cognition) score of 2 indicating severe impairment. Medical record review of a Nurse's Note dated December 18, 2011, revealed "...notified resident found sitting in the floor...no obvious injuries...bed alarm was not turned on..." Interview with Certified Nursing Assistant (CNA #1) who was assigned to the residen at the time	F 323	**This plan of correction is submitted as required under state and federal law. The facility's submission of this Plan of Correction does not constitute any admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the plan of correction cannot be used against the facility in any subsequent administrative or civil proceedings.** Resident #1 was assessed by the Nursing Supervisor on 12/18/11. No adverse outcomes noted. Resident #1 bed alarm was turned to the on position by the Nursing Supervisor on 12/18/11. Physician was notified on 12/18/11 by the Nursing Supervisor. No new orders noted. The responsible party was notified 12/18/11 by the Nursing Supervisor. Resident #1 was assessed by the Director of Nursing on 5/31/12 to ensure all fall interventions were in place. A 100% audit was conducted on 5/31/12 by the Director of Nursing for all residents to ensure fall interventions were in place as ordered. No other residents were found to be affected.	June 2, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lori Goodman, Administrator — June 8, 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JUN 12 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445458	A. BUILDING _____ B. WING _____	C 05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUR OAKS HEALTH CARE CENTER	1101 PERSIMMON RIDGE RD JONESBOROUGH, TN 37659

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F 323	Continued From page 1 of the fall in the conference room, on May 31, 2012, at 11:18 a.m., confirmed the alarm was not turned back on after the resident was placed in bed. Interview with the Director of Nursing in the conference room on May 31, 2012, at 12:03 p.m., confirmed the alarm was not in place at the time of the fall.	F 323	All Licensed nurses and Certified Nursing Assistants were in-serviced by the Nursing Supervisor on 5/31/12 – 6/2/12 to ensure fall interventions are in place. An audit will be conducted by the Director of Nursing and/or the Registered Nurse Supervisors to ensure that all fall interventions are in place and utilized as ordered. Resident # 1 along with all other residents who have fallen in the last 30 days will be audited daily for two weeks, then weekly for two weeks, then monthly for two months or until 100% compliance. Audit results will be reviewed in by the Quality Assurance / Performance Improvement Committee consisting of the Administrator, Director of Nursing, Assistant Director of Nursing, Minimum Data Set Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager, and the Activities Director.	

JUN 12 2012